

Date: _____

FEES ARE PAYABLE WHEN SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS ARE MADE. WE ARE REQUIRED TO MAINTAIN ORIGINAL X-RAYS AND RECORDS AS PROPERTY OF THIS CLINIC. X-RAY COPIES ARE AVAILABLE ON CD FOR \$10.

PERSONAL INFORMATION

Full Name _____ SS# _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ ext. _____ Cell Phone _____

Sex M F Marital Status S M D W Age _____ Birthday ____/____/____ Email _____

Race Caucasian African-American Hispanic Asian Other _____ How did you hear about our clinic? _____

Emergency Contact Name _____ Phone _____

INSURANCE INFORMATION

PLEASE COMPLETE THE ACCIDENT INJURY REPORT IF YOUR SYMPTOMS ARE A RESULT OF AN ACCIDENT

Relationship to Insured: Self Spouse Child Other

If insured is self, complete any information not listed above. If insured is someone other than yourself, please complete all information below.

Insured's Full Name _____ Insured's Date of Birth ____/____/____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ ext. _____

Insurance Company _____ Phone _____

Group # _____ Insured's ID # _____

Employed by _____ Phone _____

Additional Insurance Company _____ Phone _____

Relationship to Insured: Self Spouse Child Other

Insured's Full Name _____ Insured's Date of Birth ____/____/____

I understand that my insurance company states that this information is not a guarantee for payment and that my benefits could change or be denied. I also understand that my insurance company can take at least 60 days to respond to submitted claims and that it is my responsibility to inform this clinic of any changes in my policy. I agree to pay, in a current manner, any balance of said professional service charges over and above my insurance company's payments.

I hereby instruct and direct payment to be made by my insurance carrier to:

**Lake Mary Chiropractic Center
3240 W. Lake Mary Blvd., Ste. 1300
Lake Mary, FL 32746**

A photocopy of this authorization shall be considered as effective and valid as the original. I authorize the use of this form for all insurance claims from Lake Mary Chiropractic Center.

Patient Name _____ Patient's Signature _____ Date _____

TERMS OF ACCEPTANCE, POLICIES, AND CONSENT FOR CARE

1. All first visit charges are payable when services are rendered.
2. I authorize the taking of photographs and x-rays and performance of other diagnostic and therapeutic procedures to be used for treatment purposes.
3. I hereby give consent to have chiropractic adjustments performed in a semi-open room setting. I understand that a semi-open room setting does not ensure complete privacy and will inform the staff if I need to discuss any confidential information in private.

In order to provide for the most effective healing environment, most effective application of chiropractic procedures and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following points regarding chiropractic care and the services that are offered through this clinic:

- A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
- B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from the normal spinal structures and configurations that interfere with normal nerve processes.
- C. The chiropractic adjustment process, as defined in the "law of this jurisdiction" involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one-million times each day by doctors of chiropractic in the United States alone by doctors of chiropractic.
- D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If, during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
- E. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for the care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
- F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic.
- G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration or cost, in what we work to maintain as a supporting, open environment.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

(Signature)

(Date)

Complete if Patient is a minor child.

(Print Child's Name)

I, _____ being the parent or legal guardian of the aforementioned child have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

(Signature)

(Date)

Informed Consent For Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

Patient Name (printed)

Relationship to patient

Patient or legal Guardian Signature

Date

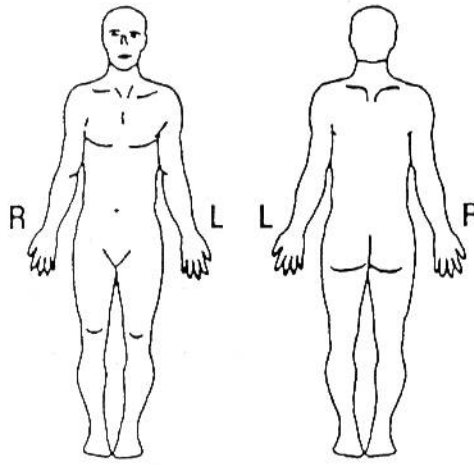
Witness Signature (office staff)

Date

PATIENT HEALTH ASSESSMENT

NAME _____ CASE # _____ DATE ____/____/____

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol to mark all affected areas.



NUMBNESS BURNING STABBING PINS & NEEDLES
 " " " X X X / / / 0 0 0


Type of care patient interested in: Temporary Relief Lasting Correction

Major Complaints

2. How would you describe pain?

Sharp Soreness Throbbing Tingling Dull Stiffness
 Spasm Burning Ache Weakness Numbness Shooting

3. How would you rate the intensity of your pain? (Circle the appropriate number)

0 1 2 3 4 5 6 7 8 9 10
 (no pain)  (terrible/unbearable pain)

4. How often is the pain present?

Constant (80-100%) Frequent (50-80%) Occasional (26-50%) Intermittent (25% or less)

How did this condition develop? _____

Any accidents, falls, etc. that might have caused your problem? _____

When was the very first time you experienced these symptoms? _____

Have you previously experienced this type of condition? _____

Has this problem been getting better, worse or staying the same? _____

Is there anything you do that makes your condition worse? _____

How is this condition affecting your:

a. Home life _____

b. Occupational life _____ Your Occupation _____

c. Recreational activities _____

d. Rest and sleep _____

Have you ever been in an automobile accident? Past year Past 5 years Over 5 years Never

Have you seen another doctor for this problem? Y N Name _____

Are you currently taking any medication? (prescriptions & OTC) Y N Specify _____

Any chiropractor consulted in the past? Y N Name _____

Date consulted ____/____/____ For what problem _____

PAIN DISABILITY QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: These questions ask your views about how your pain now affects how you function in everyday activities. Please answer every question and circle the ONE number on EACH scale that best describes how you feel.

1. Does your pain interfere with your normal work inside and outside the home?

Work normally _____ Unable to work at all
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

2. Does your pain interfere with personal care (such as washing, dressing, etc.)?

Take care of myself completely _____ Need help with all my personal care
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

3. Does your pain interfere with your traveling?

Travel anywhere I like _____ Only travel to see doctors
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

4. Does your pain affect your ability to sit or stand?

No problems _____ Can not sit/stand at all
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?

No problems _____ Can not do at all
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?

No problems _____ Can not do at all
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

7. Does your pain affect your ability to walk or run?

No problems _____ Can not walk/run at all
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

8. Has your income declined since your pain began?

No decline _____ Lost all income
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

9. Do you have to take pain medication every day to control your pain?

No medication needed _____ On pain medication throughout the day
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

10. Does your pain force you to see doctors much more often than before your pain began?

Never see doctors _____ See doctors weekly
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?

No problem _____ Never see them
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

12. Does your pain interfere with recreational activities and hobbies that are important to you?

No interference _____ Total interference
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?

Never need help _____ Need help all the time
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

14. Do you now feel more depressed, tense, or anxious than before your pain began?

No depression/tension _____ Severe depression/tension
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

15. Are there emotional problems caused by your pain that interfere with your family, social and or work activities?

No problems _____ Severe problems
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10